		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040360

Facility Name: Park Place

Address: 205 Park Avenue (Number) Pana (City) 62577 (Zip Code)

County: Christian

Telephone Number: (217) 562-7023 **Fax #** (217) 562-5516

IDPA ID Number: 371238076004

Date of Initial License for Current Owners: 05/01/93

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,203			5,203	13
14	TOTALS	5,203			5,203	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.09%

D. How many bed-hold days during this year were paid by Public Aid?
165 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/30/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified 0 and days of care provided n/a

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	A. General Services											
1	Dietary	17,559	1,800	1,929	21,288		21,288		21,288			1
2	Food Purchase		24,084		24,084		24,084	(3,038)	21,046			2
3	Housekeeping		1,703		1,703		1,703		1,703			3
4	Laundry		1,799		1,799		1,799		1,799			4
5	Heat and Other Utilities			10,215	10,215		10,215	64	10,279			5
6	Maintenance	3,465		5,922	9,387		9,387	1,019	10,406			6
7	Other (specify):*											7
8	**TOTAL General Services**	21,024	29,386	18,066	68,476		68,476	(1,955)	66,521			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	124,288	2,555	2,551	129,394		129,394		129,394			10
10a	Therapy			524	524		524		524			10a
11	Activities		5,069	262	5,331		5,331	1,702	7,033			11
12	Social Services			1,703	1,703		1,703		1,703			12
13	Nurse Aide Training											13
14	Program Transportation			1,515	1,515		1,515		1,515			14
15	Other (specify):* Routine Dental			390	390		390		390			15
16	**TOTAL Health Care and Programs**	124,288	7,624	10,545	142,457		142,457	1,702	144,159			16
	C. General Administration											
17	Administrative	31,591		6,247	37,838		37,838	(6,247)	31,591			17
18	Directors Fees							4,706	4,706			18
19	Professional Services			4,202	4,202		4,202	6,803	11,005			19
20	Dues, Fees, Subscriptions & Promotions			1,793	1,793		1,793	1,318	3,111			20
21	Clerical & General Office Expenses	14,138	3,923	7,410	25,471		25,471	9,589	35,060			21
22	Employee Benefits & Payroll Taxes			15,375	15,375		15,375	24,176	39,551			22
23	Inservice Training & Education			15	15		15	299	314			23
24	Travel and Seminar			1,606	1,606		1,606	1,966	3,572			24
25	Other Admin. Staff Transportation			275	275		275	178	453			25
26	Insurance-Prop.Liab.Malpractice							4,482	4,482			26
27	Other (specify):*											27
28	**TOTAL General Administration**	45,729	3,923	36,923	86,575		86,575	47,270	133,845			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	191,041	40,933	65,534	297,508		297,508	47,017	344,525			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park Place #0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			15,229	15,229		15,229	569	15,798			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,951	48,951		48,951	4,755	53,706			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							1,771	1,771			34
35	Rent-Equipment & Vehicles			10,128	10,128		10,128	807	10,935			35
36	Other (specify):*											36
37	**TOTAL Ownership**			74,308	74,308		74,308	7,902	82,210			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							381	381			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,082	30,082		30,082		30,082			42
43	Other (specify):* **Nonallowable costs**			134,579	134,579		134,579	(134,579)				43
44	**TOTAL Special Cost Centers**			164,661	164,661		164,661	(134,198)	30,463			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	191,041	40,933	304,503	536,477		536,477	(79,279)	457,198			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(128,222)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(973)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,093)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,576)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule 5A	(2,682)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (138,546)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	59,267		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 59,267		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (79,279)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Park Place

ID# 0040360

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

Park Place
Provider # 0040360
June 30, 2001

Schedule 5A

VI. Adjustment Detail
Line 29 - Other (Specify):

Description	Amount	Line Reference
Offset Miscellaneous Income	215	21
Out of State Travel & Seminar	(808)	43
Out of Period Professional Fees	(2,089)	19
Total	(2,682)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	64	0	0	0	0	0	0	64	5
6	Maintenance	0	36	0	0	983	0	0	0	0	0	0	1,019	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	36	0	0	1,047	0	0	0	0	0	0	1,083	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	1,702	0	0	0	0	0	0	1,702	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	1,702	0	0	0	0	0	0	1,702	16
	C. General Administration													
17	Administrative	0	1,923	0	57,000	(65,170)	0	0	0	0	0	0	(6,247)	17
18	Directors Fees	0	800	0	3,906	0	0	0	0	0	0	0	4,706	18
19	Professional Services	0	1,964	0	0	6,928	0	0	0	0	0	0	8,892	19
20	Fees, Subscriptions & Promotions	0	126	0	1,150	42	0	0	0	0	0	0	1,318	20
21	Clerical & General Office Expenses	0	5,094	0	564	3,716	0	0	0	0	0	0	9,374	21
22	Employee Benefits & Payroll Taxes	0	13,561	0	5,427	2,150	0	0	0	0	0	0	21,138	22
23	Inservice Training & Education	0	0	0	0	299	0	0	0	0	0	0	299	23
24	Travel and Seminar	0	741	0	257	968	0	0	0	0	0	0	1,966	24
25	Other Admin. Staff Transportation	0	30	0	42	106	0	0	0	0	0	0	178	25
26	Insurance-Prop.Liab.Malpractice	0	47	0	4,311	124	0	0	0	0	0	0	4,482	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	24,286	0	72,657	(50,837)	0	0	0	0	0	0	46,106	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	24,322	0	72,657	(48,088)	0	0	0	0	0	0	48,891	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	311	0	0	258	0	0	0	0	0	0	569	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,093)	369	0	3,829	2,650	0	0	0	0	0	0	4,755	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	1,771	0	0	0	0	0	0	1,771	34
35	Rent-Equipment & Vehicles	0	0	0	0	807	0	0	0	0	0	0	807	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,093)	680	0	3,829	5,486	0	0	0	0	0	0	7,902	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	381	0	0	0	0	0	0	0	0	381	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(133,771)	0	0	0	0	0	0	0	0	0	0	(133,771)	43
44	**TOTAL Special Cost Centers**	(133,771)	0	381	0	0	0	0	0	0	0	0	(133,390)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(135,864)	25,002	381	76,486	(42,602)	0	0	0	0	0	0	(76,597)	45

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc. - See attached Schedule 7A	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 36	$ 36	1
2	V	11	Activity programming		Center for Residential Management, Inc.	**			2
3	V	17	Management fees	6,247	Center for Residential Management, Inc.	**	8,170	1,923	3
4	V	18	Board fees		Center for Residential Management, Inc.	**	800	800	4
5	V	19	Professional fees		Center for Residential Management, Inc.	**	1,964	1,964	5
6	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	126	126	6
7	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	5,094	5,094	7
8	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	13,561	13,561	8
9	V	24	Travel & seminar		Center for Residential Management, Inc.	**	741	741	9
10	V	25	Vehicle expense		Center for Residential Management, Inc.	**	30	30	10
11	V	26	Vehicle, fire & liab. insurance		Center for Residential Management, Inc.	**	47	47	11
12	V	30	Depreciation		Center for Residential Management, Inc.	**	311	311	12
13	V	32	Interest expense		Center for Residential Management, Inc.	**	369	369	13
14	Total			$ 6,247			$ 31,249	$ * 25,002	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary service centers	$	Center for Residential Management, Inc.	**	$ 381	$ 381	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V				**Center for Residential Management, Inc. is				22
23	V				Progressive Housing, Inc.'s parent company.				23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 381	$ * 381	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	$	Progressive Housing, Inc.	100.00%	$ 57,000	$ 57,000	15
16	V	18	Board fees		Progressive Housing, Inc.	100.00%	3,906	3,906	16
17	V	20	Licenses, dues & subscriptions		Progressive Housing, Inc.	100.00%	1,150	1,150	17
18	V	21	Office supplies & telephone		Progressive Housing, Inc.	100.00%	564	564	18
19	V	22	Emp. benefits & payroll taxes		Progressive Housing, Inc.	100.00%	5,427	5,427	19
20	V	24	Travel & seminar		Progressive Housing, Inc.	100.00%	257	257	20
21	V	25	Vehicle expense		Progressive Housing, Inc.	100.00%	42	42	21
22	V	26	Vehicle, fire & liab. insurance		Progressive Housing, Inc.	100.00%	4,311	4,311	22
23	V	32	Interest expense		Progressive Housing, Inc.	100.00%	3,829	3,829	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 76,486	$ * 76,486	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Developmental Services of Illinois, Inc.	**	$ 64	$ 64	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	983	983	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	1,702	1,702	17
18	V	17	Management fees	65,170	Developmental Services of Illinois, Inc.	**		(65,170)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	6,928	6,928	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	42	42	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	3,716	3,716	21
22	V	22	Emp. benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	2,150	2,150	22
23	V	23	Inservice education		Developmental Services of Illinois, Inc.	**	299	299	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	968	968	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	106	106	25
26	V	26	Vehicle, fire & liab. insurance		Developmental Services of Illinois, Inc.	**	124	124	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	258	258	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	2,650	2,650	28
29	V	34	Rent expense		Developmental Services of Illinois, Inc.	**	1,771	1,771	29
30	V	35	Equipment rental		Developmental Services of Illinois, Inc.	**	807	807	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V				**Developmental Services of Illinois, Inc. is				35
36	V				Progressive Housing, Inc.'s management company.				36
37	V								37
38	V								38
39	Total			$ 65,170			$ 22,568	$ * (42,602)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Cora Flota	Director	Board Member	None	3,529	2 hrs/mtg.		Director	$ 471	L18, C8	1
2	Darrell Boehne	President	Board Member	None	13,981	2 hrs/mtg.		Director	819	L18, C8	2
3	Ed Childers	Vice President	Board Member	None	13,893	2 hrs/mtg.		Director	707	L18, C8	3
4	Kay Schuman Johnson	Treasurer	Board Member	None	3,529	2 hrs/mtg.		Director	471	L18, C8	4
5	Merla McCloud	Recorder	Administrative	None	17,722	2 hrs/mtg.		Director	678	L18, C8	5
6	Orland Bauer	Director	Board Member	None	8,122	2 hrs/mtg.		Director	678	L18, C8	6
7	Ron Schroeder	Secretary	Board Member	None	14,122	2 hrs/mtg.		Director	678	L18, C8	7
8	Robert Bauer	Director	Board Member	None	14,687	2 hrs/mtg.		Director	113	L18, C8	8
9	Eugene Humphrey	Director	Board Member	None	4,732	2 hrs/mtg.		Director	68	L18, C8	9
10	Duane Satterwhite	Director	Board Member	None	4,777	2 hrs/mtg.		Director	23	L18, C8	10
11											11
12	See attached Schedule 7A										12
13								TOTAL	$ 4,706		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	205,860	20	$ 1,284	$	5,840	$ 36	1
2	17	Management fees	Bed days available	205,860	20	288,000		5,840	8,170	2
3	18	Board fees	Bed days available	205,860	20	28,200		5,840	800	3
4	19	Professional fees	Bed days available	205,860	20	69,236		5,840	1,964	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	270		5,840	7	5
6	21	Office supplies & telephone	Bed days available	205,860	20	18,491		5,840	525	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	41,807		5,840	1,186	7
8	24	Travel & seminar	Bed days available	205,860	20	13,361		5,840	380	8
9	25	Vehicle expense	Bed days available	205,860	20	1,044		5,840	30	9
10	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	1,644		5,840	47	10
11	30	Depreciation	Bed days available	205,860	20	10,967		5,840	311	11
12	32	Interest expense	Bed days available	205,860	20	13,013		5,840	369	12
13	39	Ancillary service centers	Bed days available	205,860	20	13,408		5,840	381	13
14										14
15										15
16										16
17	20	Licenses, dues & subscriptions	Direct method						119	17
18	21	Office supplies & telephone	Direct method						4,569	18
19	22	Emp. benefits & payroll taxes	Direct method						12,375	19
20	24	Travel & seminar	Direct method						361	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 500,725	$		$ 31,630	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Progressive Housing, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	136	13	$ 409,550	$	16	$ 57,000	1
2	18	Board fees	Number of beds	136	13	33,200		16	3,906	2
3	20	Licenses, dues & subscriptions	Number of beds	136	13	9,775		16	1,150	3
4	21	Office supplies & telephone	Number of beds	136	13	4,793		16	564	4
5	22	Emp. benefits & payroll taxes	Number of beds	136	13	(162)		16	(14)	5
6	24	Travel & seminar	Number of beds	136	13	2,263		16	257	6
7	25	Vehicle expense	Number of beds	136	13	356		16	42	7
8	32	Interest expense	Number of beds	136	13	32,547		16	3,829	8
9										9
10										10
11										11
12	22	Emp. benefits & payroll taxes	Direct method						5,441	12
13	26	Vehicle, fire & liab. insurance	Direct method						4,311	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 492,322	$		$ 76,486	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	205,860	20	$ 2,273	$	5,840	$ 64	1
2	6	Repairs & maintenance	Bed days available	205,860	20	34,653		5,840	983	2
3	11	Activity programming	Bed days available	205,860	20	60,000		5,840	1,702	3
4	19	Professional fees	Bed days available	205,860	20	244,200		5,840	6,928	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	1,464		5,840	42	5
6	21	Office supplies & telephone	Bed days available	205,860	20	130,977		5,840	3,716	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	75,816		5,840	2,150	7
8	23	Inservice education	Bed days available	205,860	20	10,547		5,840	299	8
9	24	Travel & seminar	Bed days available	205,860	20	34,127		5,840	968	9
10	25	Vehicle expense	Bed days available	205,860	20	3,724		5,840	106	10
11	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	4,401		5,840	124	11
12	30	Depreciation	Bed days available	205,860	20	9,100		5,840	258	12
13	32	Interest expense	Bed days available	205,860	20	93,395		5,840	2,650	13
14	34	Rent expense	Bed days available	205,860	20	62,438		5,840	1,771	14
15	35	Equipment rental	Bed days available	205,860	20	28,457		5,840	807	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 795,572	$		$ 22,568	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IL Health Fac. Auth. - Bond		x	Acquisition of facility	Various	03/01/93	$ 4,527,000	$ 518,830	08/15/16	Varies	$ 44,749	1
2	Lease Obligation - NCS		x	Hardware/Software	$94.00	10/31/98	3,756	1,613	09/30/03	0.1429	247	2
3												3
4												4
5								Amortization of bond costs			2,487	5
	Working Capital											
6	Community Bank Galesburg		x	Working Capital	None	05/23/01	286,000	27,765	08/23/01	0.1000	3,280	6
7												7
8												8
9	TOTAL Facility Related				$94.00		$ 4,816,756	$ 548,208			$ 50,763	9
	B. Non-Facility Related*											
10							Miscellaneous Interest				2,017	10
11							Offset interest income				(76)	11
12							Non-allowable finance charges and penalties				(2,017)	12
13							Allocation from parent & management company				3,019	13
14	TOTAL Non-Facility Related						$	$			$ 2,943	14
15	TOTALS (line 9+line14)						$ 4,816,756	$ 548,208			$ 53,706	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Place COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0040360

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.	N/A		$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,625 B. General Construction Type: Exterior Siding Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	13,916	1993	$ 20,000	1
2					2
3	TOTALS	13,916		$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1992	$ 406,000	$ 10,150	40	$ 10,150	$	$ 82,891	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1995	6,700	447	15	447		2,902	9
10	Heating piping			1997	650	43	15	43		151	10
11	Shower			2000	2,266	76	15	76		76	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 415,616	$ 10,716		$ 10,716	$	$ 86,020	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 45,144	$ 4,462	$ 4,462	$	5-10 years	$ 34,618	71
72	Current Year Purchases	1,030	51	51		5-10 years	51	72
73	Fully Depreciated Assets							73
74	Allocation from parent & management company			569	569			74
75	TOTALS	$ 46,174	$ 4,513	$ 5,082	$ 569		$ 34,669	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 481,790	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,229	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,798	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 569	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 120,689	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocation from parent and management company				1,771			6
7	TOTAL				$ 1,771 **			7

8. List separately any amortization of lease expense included on page 4, line 34. n/a
   This amount was calculated by dividing the total amount to be amortized n/a
   by the length of the lease n/a .

9. Option to Buy: ☐ YES ☐ NO Terms: n/a *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 807 Description: Allocation from management company $807
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1995 Ford Van	$ 844.00	$ 10,128	17
18					18
19					19
20					20
21	TOTAL		$ 844.00	$ 10,128	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Part B MCR Supplies	L39, C8					381		381	13
14	TOTAL			$		$	$ 381		$ 381	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 935	$ 935	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	75,277	75,277	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,301	2,301	6
7	Other Prepaid Expenses	12,818	12,818	7
8	Accounts Receivable (owners or related parties)	417,137	417,137	8
9	Other(specify): Prepaid Deposit	600	600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 509,068	$ 509,068	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	415,616	415,616	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	46,174	46,174	16
17	Accumulated Depreciation (book methods)	(120,689)	(120,689)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan costs	36,886	36,886	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 397,987	$ 397,987	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 907,055	$ 907,055	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 43,731	$ 43,731	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	27,765	27,765	29
30	Accrued Salaries Payable	7,997	7,997	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	20,004	20,004	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	44,404	44,404	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 143,901	$ 143,901	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,613	1,613	39
40	Mortgage Payable			40
41	Bonds Payable	518,830	518,830	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 520,443	$ 520,443	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 664,344	$ 664,344	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 242,711	$ 242,711	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 907,055	$ 907,055	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Park Place
Provider # 0040360
June 30, 2001 **Schedule 17A**

XV. Balance Sheet

Line 36 - Other	Operating	After Consolidation
Accrued Expense	3,140	3,140
Accrued Workshop	21,533	21,533
Resident Credit Balances	1,563	1,563
Accrued Bond Payments	18,168	18,168
Total	44,404	44,404

See Accountants' Compilation Report

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 212,912	1
2	Restatements (describe):		2
3	**Prior period audit adjustment - allowance for doubtful**	(13,103)	3
4	**accounts**		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 199,809	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,625	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent & management company**		15
16	Other (describe) **allocation added back in column 7**	(89,723)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 42,902	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 242,711	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 539,851	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 539,851	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	128,222	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	953	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 129,175	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	76	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 76	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 669,102	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	68,476	31
32	Health Care	142,457	32
33	General Administration	86,575	33
	B. Capital Expense		
34	Ownership	74,308	34
	C. Ancillary Expense		
35	Special Cost Centers	134,579	35
36	Provider Participation Fee	30,082	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 536,477	40
41	**Income before Income Taxes (line 30 minus line 40)****	132,625	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 132,625	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Progessive Housing, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	51	51	1,036	20.31	3
4	Licensed Practical Nurses	2,140	2,296	25,427	11.07	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,566	2,662	17,559	6.60	15
16	Dishwashers					16
17	Maintenance Workers	308	311	3,465	11.14	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,021	2,192	24,489	11.17	20
21	Assistant Administrator					21
22	Other Administrative	296	311	7,102	22.84	22
23	Office Manager					23
24	Clerical	633	656	14,138	21.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	13,110	13,960	97,825	7.01	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,125	22,439	$ 191,041 *	$ 8.51	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	26	$ 1,929	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	9	524	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	23	1,703	L12, C3	45
46	Other(specify) Psychological	Monthly	2,387	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	58	$ 10,307		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Shaks	Administrator	0%	$ 21,080
Michell Cloe	Administrator	0%	3,409
Parent Company Allocation	See Schedule 21A		7,102
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 31,591

B. Administrative - Other

Description	Amount
	$
Center for Residential Management, Inc. - Management fees	6,247
(Management fees eliminated in Schedule V, col. 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 6,247
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consultation	$ 200
Altschuler, Melvoin &	Accounting	2,208
Glasser LLP		
American Express Tax &	Accounting	333
Business Services		
Mangum, Smietanka & Johnson	Legal	732
Lawrence Manson	Legal	729
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,202

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,496
Unemployment Compensation Insurance	1,683
FICA Taxes	14,615
Employee Health Insurance	12,967
Employee Meals	3,038
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	20
Employee Morale	466
Vaccinations	1,266
TOTAL (agree to Schedule V, line 22, col.8)	$ 39,551

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	272
Health Care Worker Background Check	
(Indicate # of checks performed 17)	119
Illinois Health Care Association	794
Miscellaneous license & fees	157
Miscellaneous dues & subscriptions	175
CARF & IL Charity Bureau	1,149
Parent & management co. allocation	45
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,111

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,059
Seminar Expense	165
Parent and management co. allocation	1,348
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,572

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Park Place
Provider # 0040360
June 30, 2001

Schedule 21C

XIX. Support Schedules
C. Professional Services

	Type	Amount
Total agreeing to Schedule V, line 19, column 3		4,202
Allocation from parent company:		
Altschuler, Melvoin & Glasser LLP	Accounting	613
American Express Tax & Business Services	Accounting	309
Mangum, Smietanka & Johnson	Legal	660
Lawrence Manson	Legal	382
Allocation from management company:		
Altschuler, Melvoin & Glasser LLP	Accounting	1,472
American Express Tax & Business Services	Accounting	702
ADP	Payroll Processing	2,549
Health Outcomes	Consulting	116
Total agreeing to Schedule V, line 19, column 8		11,005

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5							N/A						
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/00 Ending: 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $794**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **30,082**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,038** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **77%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progess**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	17,559	1,800	1,929	21,288	0	21,288	0	21,288
2. Food Pr	0	24,084	0	24,084	0	24,084	-3,038	21,046
3. Housek	0	1,703	0	1,703	0	1,703	0	1,703
4. Laundry	0	1,799	0	1,799	0	1,799	0	1,799
5. Heat an	0	0	10,215	10,215	0	10,215	64	10,279
6. Mainten	3,465	0	5,922	9,387	0	9,387	1,019	10,406
7. Other (s	0	0	0	0	0	0	0	0
8. Total Ge	21,024	29,386	18,066	68,476	0	68,476	-1,955	66,521
9. Medical	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursin	124,288	2,555	2,551	129,394	0	129,394	0	129,394
10a. Thera	0	0	524	524	0	524	0	524
11. Activiti	0	5,069	262	5,331	0	5,331	1,702	7,033
12. Social	0	0	1,703	1,703	0	1,703	0	1,703
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	1,515	1,515	0	1,515	0	1,515
15. Other	0	0	390	390	0	390	0	390
16. Total H	124,288	7,624	10,545	142,457	0	142,457	1,702	144,159
17. Admin	31,591	0	6,247	37,838	0	37,838	-6,247	31,591
18. Directo	0	0	0	0	0	0	4,706	4,706
19. Profes	0	0	4,202	4,202	0	4,202	6,803	11,005
20. Fees,	0	0	1,793	1,793	0	1,793	1,318	3,111
21. Clerica	14,138	3,923	7,410	25,471	0	25,471	9,589	35,060
22. Emplo	0	0	15,375	15,375	0	15,375	24,176	39,551
23. Inservi	0	0	15	15	0	15	299	314
24. Travel	0	0	1,606	1,606	0	1,606	1,966	3,572
25. Other	0	0	275	275	0	275	178	453
26. Insura	0	0	0	0	0	0	4,482	4,482
27. Other	0	0	0	0	0	0	0	0
28. Total A	45,729	3,923	36,923	86,575	0	86,575	47,270	133,845
29. Total O	191,041	40,933	65,534	297,508	0	297,508	47,017	344,525
30. Depre	0	0	15,229	15,229	0	15,229	569	15,798
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	48,951	48,951	0	48,951	4,755	53,706
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	0	0	0	0	1,771	1,771
35. Rent -	0	0	10,128	10,128	0	10,128	807	10,935
36. Other	0	0	0	0	0	0	0	0
37. Total O	0	0	74,308	74,308	0	74,308	7,902	82,210
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	0	0	0	0	381	381
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	30,082	30,082	0	30,082	0	30,082
43. Other	0	0	134,579	134,579	0	134,579	-134,579	0
44. Total S	0	0	164,661	164,661	0	164,661	-134,198	30,463
45. Grand	191,041	40,933	304,503	536,477	0	536,477	-79,279	457,198

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	935	935
2. Cash - F	0	0
3. Account	75,277	75,277
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	2,301	2,301
7. Other Pr	12,818	12,818
8. Account	417,137	417,137
9. Other (s	600	600
10. Total cu	509,068	509,068
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	20,000	20,000
14. Buildin	415,616	415,616
15. Leaseh	0	0
16. Equipm	46,174	46,174
17. Accum	-120,689	-120,689
18. Deferre	0	0
19. Organiz	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	36,886	36,886
24. Total L	397,987	397,987
25. Total A	907,055	907,055
CURRENT LIABILITIES		
26. Accour	43,731	43,731
27. Officer'	0	0
28. Accour	0	0
29. Short-T	27,765	27,765
30. Accrue	7,997	7,997
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	20,004	20,004
34. Deferre	0	0
35. Federa	0	0
36. Other C	44,404	44,404
37. Other C	0	0
38. Total C	143,901	143,901
LONG TERM LIABILITES		
39.Long-Te	1,613	1,613
40.Mortgag	0	0
41.Bonds F	518,830	518,830
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	520,443	520,443
46.Total Li	664,344	664,344
47.Total Eq	242,711	242,711
48.Total Li	907,055	907,055

		Balance per Medicaid Trial Balance
1.	Gross F	540,066
2.	Discour	0
	Subtota	540,066
4.	Day Ca	0
5.	Other C	0
6.	Therapy	0
7.	Oxygen	0
	Subtota-	
9.	Paymer	128,222
10.	Other	0
11.	Nurses	953
12.	Gift an	0
13.	Barber	0
14.	Non-P	0
15.	Telepł	0
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Laborá	0
20.	Radiol	0
21.	Other	0
22.	Laund	0
	Subtot	129,175
24.	Contril	0
25.	Interes	76
	Subtot	76
27.	Other	-215
28.	Other	0
	Subtot	-215
30.	Total F	669,102
31.	Gener	584,584
32.	Health	1,451,643
33.	Gener	1,455,763
34.	Owner	640,040
35.	Specia	1,279,487
35.	Provid	192,397
37.	Other	0
40.	Total E	5,603,914
41.	Incom	########
42.	Incom	0
43.	Net In	########

Page

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Park Place** **03:44 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-79,279	equal to	-79,279	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	53,706	equal to	53,706	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	15,798	equal to	15,798	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	1,771	equal to	1,771	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	10,935	equal to	10,935	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	524	equal to	524	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	381	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	68,476	equal to	68,476	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	142,457	equal to	142,457	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	86,575	equal to	86,575	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	74,308	equal to	74,308	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	134,579	equal to	134,579	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	30,082	equal to	30,082	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	124,288	equal to	124,288	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	17,559	equal to	17,559	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	3,465	equal to	3,465	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	31,591	equal to	31,591	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	14,138	equal to	14,138	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	191,041	equal to	191,041	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,929	< or = to	1,929	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,600	< or = to	3,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	164	< or = to	2,551	-2,387	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	262	-262	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,703	< or = to	1,703	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	31,591	equal to	31,591	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	6,247	equal to	6,247	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	4,202	equal to	4,202	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	39,551	equal to	39,551	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,111	equal to	3,111	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,572	equal to	3,572	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	30,082	equal to	30,082	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,038	< or = to	24,176	-21,138	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,038	equal to	3,038	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	n/a	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	59,267	equal to	59,267	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	548,208	equal to	548,208	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	20,000	equal to	20,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	415,616	equal to	415,616	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	46,174	equal to	46,174	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	120,689	equal to	120,689	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	242,711	equal to	242,711	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	132,625	equal to	132,625	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	907,055	equal to	907,055	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1